

HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-5747 FAX: (208) 364-1811

December 13, 2007

Rita Berg, Administrator Grace Memory Care of Nampa LLC 4356 North Nines Ridge Lane Boise, ID 83702

License #: RC-781

Dear Ms. Berg:

On October 22, 2007, a complaint investigation, state licensure survey was conducted at Grace Memory Care of Nampa LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Polly Watt-Geier, MSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

POLLY WATT-GEIER, MSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

Karen McDannie, R.N.

PWG/sc

c:

Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



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November 15, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0742

Rita Berg, Administrator Grace Memory Care of Nampa LLC 4356 North Nines Ridge Lane Boise, ID 83702

Dear Ms. Berg:

Based on the complaint investigation, state licensure survey conducted by our staff at Grace Memory Care of Nampa LLC on October 22, 2007, we have determined that the facility failed to retain a licensed administrator responsible for the day-to-day operations of a single facility for a period of more than 30 days. The facility failed to protect residents from inadequate care. Based on observation, interview and record review it was determined the facility admitted and retained 2 of 7 sampled residents (#5, #6) for whom the facility did not have the capability, capacity and services to provide appropriate care. The facility also failed to obtain emergency services for 4 of 7 sampled residents (#1, #2, #5, and #6) and 5 random residents. This failure had the potential to affect 100% of the residents in the facility. Finally, the facility failed to develop and implement an interim plan of care or NSA for 3 of 7 sampled residents (#2, #5, and #6).

These core issue deficiencies substantially limits the capacity of Grace Memory Care of Nampa LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **December 6, 2007.** We urge you to begin correction immediately.

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure

that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?

• What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **November 28, 2007**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (November 28, 2007). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after November 28, 2007, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by **November 22, 2007**.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Grace Memory Care of Nampa LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP

Program Supervisor

Residential Community Care Program

JS/sc

Enclosure

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIF A. BUILDING B. WING		(X3) DATE S COMPLI —	
	20 4052 OD CHODHED	101001	STREET AL	DRESS CITY S	TATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			AVE SOUTH			
GRACE I	MEMORY CARE OF I	NAMPA LLC		ID 83686	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E LSC IDENTIFYING INFORI	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	Initial Comments The following defice standard health call investigation conducting your health Conducting your health Facility Survey Definitions	ciency was cited during survey and compucted at your reside gracility. The survey we want to a survey or t	ing the plaint ntial yors	R 000			
	LOC = Level of Ca NSA = Negotiated OT = Occupationa PO = By Mouth PRN = As Needed	Service Agreement I Therapy	t				
	Pt. = Patient PT = Physical The RN = Registered r SBA = Stand By A SNV = Skilled nurr TID = Three Time	nurse Issistance sing visit				·	

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

	T OF DEFICIENCIES OF CORRECTION	[(717) 110 12 21 12 13 14 15 15 15 15 15 15 15		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		13R781				10/22	/2007
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
			422 11TH A NAMPA, ID	AVE SOUTH 83686			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
R 000	UAI = Uniform Assessment Instrument UTI = Urinary Tract Infection			R 000	·		
R 004	Requirement - 30 I	censed Administrator Days It operate for more the licensed administrate	an thirty	R 004			
	This Rule is not met as evidenced by: Based on interview and record review it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations of a single facility for a period of more than 30 days.						
	During the complaint investigation and standard survey the facility's records were reviewed at the Licensing and Certification Agency. The records documented the administrator was the licensed administrator of the facility as of 11/27/05 and of the other building as of 3/7/06. Additionally, the records documented a variance request had been received by the department on 4/25/06. A handwritten note on the variance request dated 8/7/06 documented the "facility reports no longer needed" as each facility will have separate administrators. No variance was issued at that time.					•	
	she had been and administrator for to had requested a v Certification Agendation. The facility had op without a single lice	:15 AM the administres is currently the licently of acilities. She state ariance from the Licently, but had heard not be reated for more than tensed administrator aday-to-day operation.	sed ed she ensing and response. 30 days				

Bureau of Facility Standards STATE FORM

	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED	
		13R781				10/2	2/2007
NAME OF P	ROVIDER OR SUPPLIER		İ		FATE, ZIP CODE		
GRACE I	MEMORY CARE OF N	IAMPA LLC	422 11TH A	AVE SOUTH) 83686	·		
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R 008	The administrator of procedures are impresidents are free for this Rule is not measure of the potential to affect facility. Finally, the implement an inter 6 sampled resident are impresident.	ect Residents from Informust assure that poliphemented to assure from inadequate care et as evidenced by: tion, interview, and remined the facility admined residents (#5 & id not have the capalices to provide approviso failed to obtain er sampled residents. This fact 100% of the resident facility failed to deverim plan of care or NS ts (#2, #5 and #6).	cies and that all e. ecord mitted and a #6) for bility, priate mergency #1, #2, #5 ailure had lents in the elop and SA for 3 of	R 008			
	Residents The facility's policireviewed on 10/16 admission and retefound. The adminitiand procedures hat facility, but the policompany had been of the facilities. A company's admission reviewed on 10/18 be admitted or retaservice for which the facility does not th	ission and Retention es and procedures w /07, a policy on acce ention of residents w strator confirmed the ad not been updated icies and procedures in updated and were different facility within sion and discharge poly /07. It documented " ained who requires a he facility is not licen ine facility does not pro thave the personne ers and the appropria	rere ptable as not policies at the for the used for all the olicy was no one will type of sed to rovide or if I in the				

	TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BÜILDING B. WING	E CONSTRUCTION .	(X3) DATE SURVEY COMPLETED 10/22/2007			
NAME OF P	ROVIDER OR SUPPLIER	13R781	ĺ	ADDRESS, CITY, STATE, ZIP CODE					
GRACE I	MEMORY CARE OF N	IAMPA LLC	422 11TH NAMPA, II	AVE SOUTH 0 83686					
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R 008	Continued From page 3 to provide such services."			R 008					
	January 2007 thru	ty's as worked sched June 2007, revealed Eduled on the night si	there was						
	revealed he was ad diagnoses which ir hypothyroidism, hy secondary to recer	ent #5's record on 10 dmitted on 4/18/07 w ncluded dementia, ponatremia, petechia nt medications, prost on deficiency anemia	ith al rash atic						
	"Cumulative Asses 4/17/07 thru 4/18/0	lobility: Review of Ho ssment Chart Copy" ()7 documented, "Ger with the assistance o	dated neralized						
	A's "Last 24 hr Ass 4/18/07. It docume supervision while i the resident needs	ed record contained sessment Chart Copented he required a son the hospital. It doced a 2 person assist very inconsistent with the content with	y" dated itter for umented with						
	4/18/07 document the halls at the hos walker and neede	I A's discharge sumr ed Resident #5 wand spital and required th d to "be monitored or ion when ambulating	dered in se use of a r have						
	dated 4/19/07 doc found to be "lethal ambulate or speal assistance of two	ummary/Physician O sumented Resident # rgic" and had an inat k and required maxin caregivers for all tran assisted living facility	5 was bility to num nsfers. It						

Bureau of Facility Standards STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLE	ETED
	13R781				10/2	2/2007
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PREFIX (EACH DEFICIENCY N	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
"willing to attempt ca HH A's physical there documented Resider weak and lethargic. I dependent on caregi documented his bala constant contact ass balance. It document to provide a 2 persor The facility's daily log 11-7 shift documente "had rolled out of the HH A's "Generic Nur 4/21/07 documented ambulate." The resic planned to visit "freq with cares. The facility's daily log shift documented wh Resident #5 at 11:30 he collapsed. The ca my best to get him to found him kneeling of picked him up off of not participate in the documented that be Resident #5 had bee and each time the ca Additionally, Resider floor at 3:30 AM and chair. Resident #5 h The facility's daily log 3-11 shift document walking from one ch walking, "not hard no	apy note dated 4/19 nt #5 was "very grog It documented he w ivers for all mobility. ance was poor and it sistance to help main ated caregivers were in assist as needed. It note dated 4/20/0 and at 3:30 a.m., Reserved at Resident #5 was " dent's family member it acaregiver was a continued and acaregiver was a continued to the bed." The care in the floor at 1:30 and a transfer. The care is the floor because he are transfer. The care is the floor because he are found on the floor at 1:30 and and a falls during this and 6 falls du	ggy", ras . It also required ntain required ntain rewilling" 7 on the sident #5 lated unable to reschibly rassisting the toilet, red, "tried regiver AM and regiver also 12:30 AM or 3 times and on the diput in a significant red been relied while	R 008			

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R781			A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPL	
				B. WING		10/2	2/2007
NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
GRACE	MEMORY CARE OF N	IAMPA LLC	422 11TH . NAMPA, ID	AVE SOUTH 83686			
(X4) ID PREFIX TAG			'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 008	and I picked him up back up on feet with 11-7 shift documer 3:30 AM kneeling cassistance back in HH A's "Generic N 4/25/07 documents without sleeping m family members ar to have the resider ambulation and traresident had 3-4 up	o, he was fine, real h h 2 people." og note dated 4/22/0 nted Resident #5 was on the floor and requ	of on the s found at ired dated up at night resident, astructed all the ng the	R 008			
	documented Resident or moved self out of times." It also documesident 4 times prodiscontinued "due physical therapist is but do not know, the services] is due to we have concerns appropriate level of HH A's "Home Care Records" data and 12:30 PM document of the several falls during were noted, althout very difficult to trarrequired 2 and 3 pund to the resident of the self-out of t	lent #5 had "slipped of chair or bed onto fumented that PT had ior to the services be to caregiver request further documented, hat this [discontinuati caregiver being offe that patient may not f care." The Services Coordinated 4/25/07 between umented Resident # hight where not go it was documented for the floor. The eople for transfers a this confusion and we ressed concern to the services of the floor.	last night floor 5 I visited the eing "The "I believe, ion of nded that be in ation of 11:30 AM 5 had o injuries ed he was He nd mobility akness.				

Bureau of Facility Standards STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDING	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		13R781		B. WING		10/22	2/2007
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
GRACE I	MEMORY CARE OF N	IAMPA LLC	422 11TH A	AVE SOUTH) 83686	`		
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R 008	develop long range also spoke with the facility's ability to concern the facility's ability to concern the facility's daily 13-11 shift document floor 4 times. The facility's daily 11-7 shift document [including Resident lemonade, needed could do rounds. 3 #5] all trying to go The facility's daily 3-11 shift docume "around a lot won't the floor at 10:30 gwait for another can transfers. The facility admitted who required a 2 that transfers. The Resident #5 because scheduled on the AM. B. Urinary retention Resident #5's closs admitted to the hot there for 10 days, facility on 5/7/07. Foley catheter plans ability on 5/7/07. Foley catheter plans ability on 5/7/07.	encouraged the family plans in care. The he house manager regare for him at this "standard for him at this "standard for him at the number week." log note dated 4/26/0 and the Resident #5 was log note dated 4/26/0 and there were "6 reat #5] all up, made point to keep them occup is residents [including in others rooms." log note dated 4/27/0 and the caregiver "to get him used and retained Resident #5 was to any and the caregiver "to get him used and retained Resident was not able use they had only one night shift from 11:00 and/catheter care: Revised record indicated he spital on 4/28/07 and then was re-admitted while hospitalized he ced and was dischar Home Health B, whice	H nurse arding the age." The rse is 7 on the son the 7 on the sidents poorn and ied so I Resident 7 on the ndered so found on er had to p." dent #5 h mobility to care for e caregiver of PM-7:00 iew of the was I remained in the son the son the was I remained in the son the	R 008			

Bureau of Facility Standards STATE FORM

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NO 13R781		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	CTION (X3) DATE S COMPLE	
NAME OF S	ROVIDER OR SUPPLIER	1017.01	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE	1 4/2	
	MEMORY CARE OF N	IAMPA LLC		AVE SOUTH			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 008	HH B's nurses prog 6:45 PM document Resident #5 due to catheter with the poremoved traumatic with the catheter and "expressed their in wrong doing." The instructions to family documented evidereceived similar insin catheter care. And advise [Family men and consider wheth appropriate." The facility's daily I 3-11 shift documented evider the catheter and his which the HH nurs PM a family member him not having any The facility's daily I 11-7 shift documented evidere area twice. The "Everything seeme emptied cath bag of the facility admitted who required exteresident's Foley catheter and regar C. Fluid Restriction	gress note dated 5/10/ed the HH nurse vision him trying to remove assibility it could have ally. He had a "preoped the family members ability to sit with Pt. HH nurse gave cather and the facility caregistructions or had been diditionally, the HH number] to eval Pt's new their current LOC is and some bleeding are evaluated. At around the catheter fluid in the catheter and the caregiver had been and the caregiver document of the beautiful to be working pro-	sited we the we been ccupation" ers to prevent neter ere was no givers had en trained ourse "did eed of care 07 on the d pulled on nd pain, and 9:20 ER due to r bag. 07 on the d not been pleeding I cleaned nted perly ident #5 monitor the co had not	R 008			

Bureau of Facility Standards

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF A. BUILDING B. WING	****	(X3) DATE S COMPLI	ETED
		13R781		The state of	TATE TIP CORE	1 10/2	2/2007
NAME OF P	ROVIDER OR SUPPLIER				TATE, ZIP CODE		
GRACE I	MEMORY CARE OF N	NAMPA LLC	NAMPA, IC	AVE SOUTH 0 83686			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL.	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
R 008	Continued From pa	age 8		R 008			
	throughout the day	nking large amounts ." Discharge instructi lorie ADA diet with a	ons				
		r dated 4/18/07 docui laced on a 2 L fluid re		THE PARTY OF THE P			
	HH A's "Start or Resumption of Care" dated 4/19/07 documented the resident was on a 2 L fluid restriction.						
	discontinued on 4/2 was admitted for a Hospital B and ren	Resident #5's closed record indicated HH A was discontinued on 4/27/07. On 4/28/07 the resident was admitted for an unresponsive episode to Hospital B and remained there for 10 days then was re-admitted to the facility on 5/7/07 with HH 3.				,	
	4/28/07 documents of significant PO ir 9 liters per day." It the emergency roo not as "severe" as Additionally, it doc	I B's history and physed Resident #5 had " htake of fluids at that documented he presom with a low sodium when he was at Hosumented he had "eviet treat with Lasix and	a history time, 6 to ented to level, but pital A. dence of				
	Plan of Care" date agency was to ass	"Home Health Certified 5/8/07 documented sess nutrition and hyd ance with fluid restric	the HH Iration				
	documented Reside to monitor with fluit will try hard diabet cooperate with me	ress note dated 5/8/0 dent #5 continued "to ds, esp. water intake ic candy, gum, ice ch when I told him he c is is problematic to th	be difficult , and they lips. He did ould not				

Bureau of Facility Standards

	T OF DEFICIENCIES OF CORRECTION	CTION IDENTIFICATION NUMBER: A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED		
						10/22	2/2007
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
GRACE	MEMORY CARE OF N	NAMPA LLC	422 11TH NAMPA, I	AVE SOUTH D 83686			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
R 008	Resident #5's recotransmission/phondocumented, "Reswith 1500 ml (1.5 Ito have this order ambulatory with debe monitored in this responded "pt. has hyponatremia, fluid required!!" The facility admitted who required extended the was no dochad monitored his 4/28/07. Additional	age 9 ord contained a "Fax e order" dated 5/9/07 ident returned to this iter) fluid restriction. removed because re ementia. His fluid inta is setting." The physis is polydipsia with assid restriction is medic ed and retained Resi nsive monitoring of f umented evidence the fluid intake from 4/1 illy, there was no documented was re-admitted	s facility We need sident is ake cannot cian ociated ally dent #5 luid intake. ne facility 8/07 to cumented	R 008			
	The facility admitted who required extermobility, toileting a fluid restrictions, when being above LOC 2. Resident #6 was 7/15/06 with diagr	as admitted to the fac noses which included	ident #5 nce with ons and resident cility on I dementia,				
	On 5/14/07, a fax documenting the hip and pelvis are weight on that leg	I macular degeneration was sent to the physical resident had bruised to and was unable to any "leg wobbly." esident was taken to ght pelvis fracture. To the facility with a resident was taken to the facility with a resident was the facility w	sician the right bear the ER and he resident				

	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIF A. BUILDING B. WING		(X3) DATE S COMPLI	ETED
		13R781	OTDEET ADE	DECC OTTY O	TATE, ZIP CODE	10/2	2/2007
•	PROVIDER OR SUPPLIER MEMORY CARE OF	NAMPA LLC		AVE SOUTH	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
R 008	Resident #6's clos "Patient Transfer If documented she was right lower extremordered PRN for in Resident #6 was a was assessed as unable to ambulat transfer self and unable when transferred if documented the rewould be assessed. The facility's nurse documented Resident was admit to a self and was in the facility's nurse documented Resident was admit to a self and the self documented Resident was admit to a self all times. On 10/16/07 at 10	ed record contained a Form" dated 5/21/07, was non-weight bearing ity. A knee immobilized from weight bearing standard the date of the following the end of the factory another person. It is esident had a large by another person. It is esident had a large by day PT and OT for positive and the factory a	which and with the ar was atus. 3/07. She atus. 3/07. She and, able to or pivot also race and roper use. 3/07 to the ality on 5/31/07 the ated 6/7/07 rson assist anager	R 008			
	at night but "if nees someone else to it on 10/16/07 at 11 the Resident #6 w resident was unable to wheel h	ras only 1 caregiver so eded that person could help." 1:00 AM a HH nurse so ras re-admitted on 5/2 pole to bear weight or perself and was totally ff for all of her cares	tated after 21/07, the bivot,				

Bureau of Facility Standards

R 008 Continued From page 11 On 10/16/07 at 11:15 AM the administrator stated she occasionally had reservations about admissions, but the owner of the facility would "override her decision on who was an acceptable admission and who was not." On 10/16/07 at 11:30 a.m., when the facility RN was asked about residents who required a 2 person assist at night, the facility RN stated "if the resident is on hospice, the resident would be left in bed and turned every two hours. If the resident should fall during the night, when only one person is on, staff would call 911 to assist with getting		IT OF DEFICIENCIES OF CORRECTION	CTION IDENTIFICATION NUMBER:		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPLI	
GRACE MEMORY CARE OF NAMPA LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) R 008 Continued From page 11 On 10/16/07 at 11:15 AM the administrator stated she occasionally had reservations about admissions, but the owner of the facility would "override her decision on who was an acceptable admission and who was not." On 10/16/07 at 11:30 a.m., when the facility RN was asked about residents who required a 2 person assist at night, the facility RN stated "if the resident is on hospice, the resident would be left in bed and turned every two hours. If the resident should fall during the night, when only one person is on, staff would call 911 to assist with getting					B. WING		10/2	2/2007
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The facility admitted and retained Residents' #5 and #6 who required a 2-3 person assist with mobility and transfers while having 1 caregiver on the night shift from 11:00 PM - 7:00 AM. Additionally, Resident #5 needed extensive to total assistance with toileting and/or urinary conditions and fluid restrictions for which the facility did not have the capability, capacity, and services to provide the appropriate cares. II. Emergency Intervention 1. Review of Resident #5's closed record on 10/16/07 revealed the resident was admitted on 4/18/07 with diagnoses which included dementia, hypothyroidism, hyponatremia, purpuric rash secondary to recent medications, prostatic hypertrophy and iron deficiency anemia. Resident #5's closed record contained Hospital A's "Last 24 hr Assessment Chart Copy" dated 4/18/07. It documented he needed a 2 person assist with mobility and was "very inconsistent with mobility and at risk for falls."	R 008	On 10/16/07 at 11: she occasionally had admissions, but the "override her decis admission and who on 10/16/07 at 11: was asked about reperson assist at nigresident is on hospin bed and turned a should fall during the resident up." The facility admitted and #6 who require mobility and transfethe night shift from Additionally, Resid total assistance wire conditions and fluic facility did not have services to provide II. Emergency Inte 1. Review of Resident #18/07 with diagn hypothyroidism, hy secondary to receiphypertrophy and in Resident #5's clos A's "Last 24 hr Ass 4/18/07. It docume assist with mobility	15 AM the administrated reservations about a owner of the facility ion on who was an appropriate care was not." 30 a.m., when the face esidents who require got, the facility RN states and the face of the resident work and the night, when only of all 911 to assist with the night, when only of all 911 to assist with the tolleting and/or uring the tolleting and/or uring the capability, capate the capability, capate the appropriate care revention the resident was adroses which included reponatremia, purpuricant medications, prost on deficiency anemiated record contained sessment Chart Copyented he needed a 2 of and was "very incording and was "very	t would cceptable cility RN d a 2 ated "if the ald be left e resident one person getting dents' #5 st with a regiver on l. sive to nary ch the city, and es. rd on mitted on dementia, c rash atic a. Hospital y" dated person	R 008			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	N NUMBER: A. BUILDING		(X3) DATE SI COMPLE	ETED	
	13R781		B. WING		10/2	2/2007
NAME OF PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		İ
GRACE MEMORY CARE OF N	IAMPA LLC	422 11TH NAMPA, II	AVE SOUTH 0 83686			
PREELY (EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 008 Continued From pa	age 12		R 008			
3-11 shift documer walking from one of walking "not hard rand I picked him up back up on feet wild documented evide completed or if the incident and assess. The facility's daily 3-11 shift documer floor 4 times. Therevidence of an incifect from the facility RN has and assessed or into care for the resist. The facility's daily 3-11 shift documer "around a lot won't found on the floor had to wait for another was no docincident report bein RN had been notifect for the resident responsive all thospital." There was an incident report RN had been notifect for the resident report RN had been notifications.	nted Resident #5 had thair to another and foo injuries. Another cap, he was fine, real high 2 people." There we note of an incident reports had been notified the resident. Tog note dated 4/26/0 anted Resident #5 was to documente ident report being conditionally and the incident after the incident at 10:30 PM, and the other caregiver "to ge umented evidence of any completed or if the incident and the caregivers of the incident and the incident and the incident and the incident and the caregivers of the incident and the incident and the incident and the incident and the incident and the incident are incident and the caregivers of the incident and the inciden	ell while aregiver and to get vas no port being fied of the room the son the dependence on the endered sident was a caregiver thim up." If an endered sident was a caregiver thim up. The facility and on how to room the room to widence of the facility and on calling sical dated				

Bureau of Facility Standards STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLII IDENTIFICATION NU			(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPL	ETED	
		13R781	,			10/22/200	
NAME OF F	PROVIDER OR SUPPLIER			DRESS, CITY, ST	ATE, ZIP CODE		
GRACE	MEMORY CARE OF N	NAMPA LLC	422 11TH NAMPA, II	AVE SOUTH D 83686			
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R 008	of unresponsiveness and inability to awaken him for approximately 8 hours. It started around 3-4 am on the morning of admission and continued till about 12 or 1 pm." "they tried multiple ways of awakening him, he was just unresponsive but was with normal vitals. A home health nurse went to check on him as well and again his vitals were appropriate but he was unresponsive. They called the ambulance." Review of Resident #5's closed record indicated HH A was discontinued on 4/27/07. It also		R 008				
	He remained at the was re-admitted to hospitalized the replaced and was diwith HH B, which was a second to the remained at the was re-admitted to the re-admi	ode to Hospital B on e hospital for 10 days the facility on 5/7/07 sident had a Foley ca scharged back to the was initiated on 5/8/0	s and then 7. While atheter s facility 7.				
	PM, documented to #5 after he tried to possibility of remo no documented ex being completed contified of the incide.	press note dated 5/10 the HH nurse visited premove the catheter ving it traumatically. Vidence of an incident or if the facility RN had bent and assessed ocalling emergency seal attention.	Resident r with the There was t report d been r instructed				
	3-11 shift docume the catheter and h which the HH nurs PM, a family mem there not being an There was no indiinstructed the care catheter was not we	log note dated 5/10/0 Inted Resident #5 had ad some bleeding ar se evaluated. At arou aber took him to the E by fluid in the cathete cation the facility RN egivers on what to do working properly. Add ange in condition the	d pulled on and pain and 9:20 ER due to r bag. had bit the ditionally,				

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	T OF DEFICIENCIES DF CORRECTION	TION IDENTIFICATION NUMBER: A. BUILDING B. WING					
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	ROVIDER OR SUPPLIER MEMORY CARE OF N	IAMPA LLC	1	AVE SOUTH			
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R 008	was not involved at Resident #5 for me The facility's daily I 11-7 shift documer complaining of pair bleeding from the 'cleaned the area to documented "Ever properly emptied chad not given instror after he had pul monitor or how to working properly. The facility's daily 11-7 shift documented properly emptied chad not given instror after he had pul monitor or how to working properly. The facility's daily 11-7 shift documented remember took the as "the ER urinally white/red blood ce tremendous pain in documented evide completed due to of pain. There also the caregiver had change in condition assessed or instrutor emergency ser Hospital B's recomwas seen in the endication of the diagnoses which in and rentention of and rentention of the series of th	and a family member edical care. og note dated 5/10/0 nted Resident #5 had noted. The caregiver ything seemed to be eath bag x 2." The fact date out the catheter of the cath	or on the d not been ad been giver had been giver had a working cility RN vers during on what to was of ing of was no eport being complained d evidence N of the RN had on the need bident #5 6/17/07 at which mily called or "He was h of intestine"				

		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/22/2007		
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NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE			
GRACE	MEMORY CARE OF I	NAMPA LLC	422 111H . NAMPA, IE	AVE SOUTH) 83686				
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R 008	perforation and a "subacute rib fractuon on 10/17/07 at 9:3 the resident had meeded supervision become confused stated the resident weak all of a suddusually hard. She her at one point ar fallen and she couns on 5/17/0 caregiver told the been in pain all night family member the during the night if called and he had took him to the EF had a broken rib, properly spleen. On 10/17/07 at 10 member stated the with mobility and very physician's visit it assist the resident she was not award injuries. She state had a BM 3 days phospital on 5/17/0 any others after the taken him to the pwhere at that time	splenic fracture with a	per stated at the time sident lent would king. She ecome not d called at had by herself, he early lent sident had to told the sked uld be nember sined he ruptured nilly sistance ent to a pers to stated falls with resident d to the had lend he had lend lend he had lend lend of lend of lend of lend lend lend lend lend lend lend lend	R 008				

On 10/170/7 at 3:00 PM, a caregiver stated

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER 13R781			(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPLI	
			I	2000 0174 07	ATE ZID CODE	10/2	2/2007
	PROVIDER OR SUPPLIER MEMORY CARE OF N	NAMPA LLC		AVE SOUTH			
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R 008	Continued From particles Resident #5 requires improved and then wandered all of the Additionally, she stand would get him. The facility failed to intervention in a tire had an unresponsive removing a catheter falls without nursing interventions. Additionally was pain for an extend found to have a fra perforated bowel. 2. Resident #6 wa 7/15/06 with the formal requirements of the perforate formal residents.	age 16 ed heavy care initially became worse againe time and did not like tated she had never sut he was on the ground	esident #5 ter ere several cy nplained of was later acture and lility on ementia,	R 008			
	Resident #6's closs nursing assessmed documented the reference frequently appear frequent falls from attempting to stan wheelchair." An accident/incide PM, documented floor and first aid right elbow. There facility RN had be incident and the fall 1/29/07, 10 days a Additionally, there of an investigation	sed record contained ent (2/07-4/07) which esident was "alert, cors anxious and verban bed (alarm put on) find and walk while up ent report dated 1/19/Resident #6 was fou was applied to skin the was no documentation notified at the time actility RN signed the after the incident occe was no documented on, or that the facility Fer the incident or had	a quarterly onfused. Ily shouts, following in 107 at 1:30 and on the ear on the ear on the report on urred. It evidence the extra the evidence the e				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENTIFICATION N			A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL		
	13R781 AME OF PROVIDER OR SUPPLIER STI			B. WING	10/2	2/2007	
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GRACE	MEMORY CARE OF N	IAMPA LLC	422 11TH NAMPA, I	AVE SOUTH D 83686			
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R 008	nursing instructions care for her after the daily log notes documented Reside medication (not sport of the daily log notes documented Resideration (not sport of the day." The daily log notes identified) documented hydrocodone 1/2 to documentation the Resident #6's closs to the physician, which was no documented the reand had complainted for a mobile x-ray physician ordered and the nurse note was no documented the nurse note was no documented the fall. The daily log notes shift documented hydrocodone at 5: There was no documente	s to the caregivers or ne incident. dated 1/22/07 on the lent #6 was given pa ecified). dated 1/28/07 on the lent #6 was having "a ot specified), laying in there was no docume	e 7-3 shift in e 7-3 shift a lot of n bed entation not s given was no n notified. a fax sent /07. It 1/26/07 . A request ne 1/29/07 07. There received n after vain. e 3-11 en for pain. Ey RN had belvis and becument n on	R 008			

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	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R781			(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPLI	ETED
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R 008	Continued From pa	age 18		R 008			To the state of th
	documented Residual day and continued	s dated 2/1/07 on the lent #6 was in bed m to complain of back umentation the facility	ost of the pain.				
	documented Resid	s dated 2/1/07 on the dent #6 was given PF specified) at 4:00 PM	RN				
	documented Residuals was complaining of sent to the ER. The evidence an incidence completed. The factors are the completed and the completed are the completed are the completed are the completed are the completed are the completed are the completed are the completed are the completed are the completed are the completed are the completed are the completed are the complete are th	s dated 2/2/07 on the dent #6 fell and hit he of back and head painere was no documerent/accident report had illity RN documented sident transports in was deated.	er head, n and was nted ad been d in the				
	documented Residence (not specified) wa	s dated 2/9/07 on the dent #6 was in pain, s given and she was cumentation the facili	a "PRN" put to bed.				
	shift documented hydrocodone at 9	s dated 2/12/07 on the Resident #6 was give :00 PM. There was noted the e facility RN had bee	en o				
	documented Resi PM. The accident documented the i She was found or scrape on the righ She was given 2	g notes for the 3-11 sident #6 fell out of be lincident report dated notident occurred at 8 not the floor and had or not elbow which was be Tylenols. There was e facility RN was not	d at 9:00 d 3/7/07 3:15 PM. ne small andaged. no				

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/22/2007	
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	PROVIDER OR SUPPLIER MEMORY CARE OF N	NAMPA LLC	1	AVE SOUTH			
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R 008	incident until the notincident/accident reaction ally, there the facility RN had or had given nursing caregivers on how the incident. The daily log notes documented Resident was given Tyledocumentation the The facility's nurse documented Resident and holding a The physician was for an x-ray which documented evident medical care or enholding the anterior An x-ray was commindicated Residentib, 5 days after the facility RN had the incident or had caregivers on how An accident/incident or and skin tean There was no indinotified. There was facility RN had as fac	ext day when the eport was signed as was no documented assessed her after the ingrinstructions to the to care for the resident #6 had complained. There was no efacility RN had been to entire the ingression of the entire to the entire the entire the entire the entire the entire the entire the resident had mergency intervention rib and burping. The entire the resident had mergency intervention rib and burping. The entire the entire the entire the entire the resident fell. The entire the ent	ent after e 7-3 shift ned of pain n notified. ining of n burping. n a request was no d received on after /hich er left ninth nurse's a fracture d evidence t #6 after to the //// at 3:45 ind on the l bandaged. N was r action tion the icted the	R 008			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER		1		TATE, ZIP CODE			
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R 008	Continued From pa	age 20		R 008				
	AM documented R her bed, bleeding funlicensed caregives see any need for soleaned and her old documented evides care or emergency bleeding from the no documentation notified or assessed occurred. The report of the seeding from the notified or assessed occurred.	nt report dated 4/10/0 desident #6 was foun- from her head and el- ver had documented, ditches." The wound othing changed. The ence she had receive y intervention after be head. Additionally, the the facility RN had be ded her injury on the dort was signed by the n 4/12/07, 2 days after	d beside bow. The did not was are was no d medical eing found ere was een ay it e facility					
	PM documented if wheelchair to the tear on the left for upper arm right at second fall and wainjury. At 6:23 PM bathroom which retear on left arm. The bandaged. There facility RN had be after sustaining 3.	ent report dated 4/29/ Resident #6 fell from floor resulting in a lar earm and small skin cove the elbow. She as "assessed" not to she fell a third time if esulted in another small in another small was no documentation of the arm was treated as falls on the day they gned by the facility Report of the falls occurred.	her rge skin tear on left had a have any in the hall skin and on the sessed her occurred.					
	shift documented in the leg. There is facility RN was not after complaints of the daily log notes shift documented	es dated 5/10/07 on the Resident #6 compla was no documentation of pain. es dated 5/10/07 on the Resident #6 was "verained of pain, ate not	ined of pain on the ed her leg he 3-11 ery					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPI A. BUILDING B. WING		(X3) DATE S COMPLE	ETED	
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R 008	dinner and kept fall screaming." There facility RN was not The daily log notes shift documented I checked and the "I had complained et accident/incident in documentation the or had assessed in no documented ex medical care or er sustaining a possi An accident/incide time listed) docum against the wheeled of skin to tear. The bandaged. The acsigned by the facil documentation the or assessed the s	lling asleep and woke was no documentati ified or had assessed adated 5/11/07 on the Resident #6's legs we pinky toe looks broke arlier that it hurt." The eport found and no e facility RN had been are toe. Additionally, to the broken toe. Interventionally ble broken toe. The ented Resident #6's chair and caused the ewound was cleaned coident/incident reportity RN and there was a facility RN had bee kin tear.	e 3-11 ere en and she ere was no n notified there was sived n after 07 (no leg rubbed top layer d and t was not s no n notified	R 008				
	documenting Res and pelvis area ar that leg, "leg wobl mobile x-ray whic to send her to the evidence she was	O7, was sent to the plident #6 had a bruise and was unable to be ably." The request was he the physician denies ER. There was no desimmediately taken that as she was not seen	ed right hip ar weight on a for a led and said locumented to the				,	
	admitted with a righteen no report of and on 4/29/07 standard to the house	lent #6 was taken to ght pelvis fracture. T a fall since 4/29/07 (he fell 3 times. She w ospital to "keep comf p and plan for discha	here had (16 days) vas fortable,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
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GRACE	MEMORY CARE OF N	IAMPA LLC	NAMPA, II				
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R 008	Surgery was not elerecommendation. On 10/16/07 at 3:2 the event a residen if they are okay or iresident says no, where they are okay or iresident says no, where they are okay or iresident says no, where they are okay or iresident says no, where they are okay or iresident says no, where they are okay or it is a said the nurse but once when a reside said the house maid daughter and the downward of an em "looked over, if sor family and if serious name]. Further, they don't know how to just by the look [of will tell me." On 10/16/07 at 3:3 procedure in an enchoking or not breat family and then they name]. The facility failed to intervention and/or manner when Resident when Resident/accident we emergency services. 3. Resident #2 was a say or if they are okay or incident/accident we mergency services.	ected per physician's O PM a caregiver stant falls the procedure if they can stand up. we call the family or the ver admitted she had at did call the house re ent fell and hit her he mager told her to call laughter said that it of 5 PM a caregiver stant ergency the resident mething is wrong I can is I call [house mana is caregiver stated, "I tell if it's something is the resident] or the re in O PM a caregiver stant ergency was to call athing, otherwise to contact in entire the supervisor [house re in obtain emergency in medical care in a tir ident #6 had sustained ation to the head, brut ites from falls. The far aregivers in the even when to contact her of	ted that in is to "ask of the me ER." In ever manager and. She the ould wait. It was are all the ger's really serious, esident at the sall the manager's mely ed several ising, cility RN to of an robtain lity on	R 008			

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STATE FORM

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLII		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLI	ETED
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NAME OF P	PROVIDER OR SUPPLIER		1		TATE, ZIP CODE		
GRACE!	MEMORY CARE OF N	NAMPA LLC	422 11TH NAMPA, II	AVE SOUTH D 83686			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCE Y MUST BE PRECEDED B' LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 008	Continued From pa	age 23		R 008			
	documented Resider found on the floor and then the facility RN was called and then the facility RN was called and after. En obtained after it was member. The resider fracture. On 10/19/07 at 2:4 Resident #2 was four with her leg turned members (including resident into a whole emergency service)	ent report dated 9/19/dent #2 called for hel at 7:30 AM. Under the in it documented the elambulance was called on 9/19/07 at 9:00 mergency services was requested by a fadent was hospitalized 43 PM a caregiver stround on the floor on doutwards and two sing herself) transferre elichair prior to obtain the said to send the date of the said to send the date of the said to send the said to send the	Ip and was he son was illed. The O AM, 1 ere mily d with a hip ated 9/19/07 staff ed the ining said the				
	intervention and/o manner when Res fracture. The facili caregivers in the e	to obtain emergency or medical care in a ti sident #2 had sustair ity RN had not direct event of an incident/a er or obtain emerger	imely ned a hip ed accident				AAAAA AAAAA AAAAAAAAAAAAAAAAAAAAAAAAAA
	4. Incident Report Random Resident	ts of One Identified a ts	nd Six				
	reviewed and reve An incident report documented Rand "walking strange, had three small cu of his nose, one b	ncident/accident log ealed the following: t dated 5/28/07 at 5:0 dom Resident C was he was leaning forwatts uts on his face: one foelow the eyebrow, on Resident C had diffi	D2 PM s noted as ard he also to the side one below				Wilder Control of the

		F		 		1	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE S COMPL	
		13R781		B. WING		10/2	2/2007
NAME OF P	ROVIDER OR SUPPLIER	***************************************	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
GRACE I	MEMORY CARE OF N	NAMPA LLC	422 11TH NAMPA, II	AVE SOUTH 0 83686			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
R 008	food to eat." It documents the how to care for him. An incident report documented Rand move a chair away. Random Resident Resident A to a chair. Additionally, caregivers assisted chair. Additionally, caregivers to checonot document if the incident and there assessment complication. An incident report document if the incident and there assessment complication. An incident report documented Random Resident. kept putting his hands umented Random Re- aning and bandaging was notified by care in, but the incident re- lad been assessed by caregivers were insti- n after the incident. dated 6/6/07 at 1:18 om Resident A attem from the table. It do A became unsteady B tried to assist Ran air. Both residents fe- sident A fell on the rig inplaints of pain. Two d Random Resident the resident refused k vitals. The incident e nurse had been no was no documented leted of his condition dated 6/6/07 at 1:18 lom Resident B was assist Random Resid ents fell, but Randon arm of green chair." ained of pain to right range of motion withir ent B was assisted by chair. The incident re- cility RN had been no here was no documen bleted of his condition	esident C his egivers on port did y the ructed on PM npted to cumented and dom ell on their ght side. A in the treport did tified of the after the PM sitting at a tent A into n Resident Random elbow and n normal y two port did not otified of nted n after the	R 008				
	An incident report	dated 6/8/07 at 11:4	U AM				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPLE	
		13R781	T awa === 1 ===	DE00 01714 07	ATE ZID CODE	10/2	LI LUU I
	ROVIDER OR SUPPLIER MEMORY CARE OF N	NAMPA LLC	1	AVE SOUTH	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL]	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 008	documented Rand the floor after a car cleaning up feces injuries or bruises and asked him if h The facility RN had 6/15/07, 7 days aft report did not docuby the RN or if and instructed on how incident. An incident report documented Rand the floor with his up in BM. I believe he because poop was another caregiver with getting him in also documented, bruises I can't tell and put the resides signed the incident. The inhe had been assed the caregivers we him after the incident. The incident report documented Rand walk on his own a wheelchair. He feen the counter." He for the counter on the counter on the counter on the counter on the counter on the counter on the counter on the counter on the counter of the incident of the inci	om Resident B was fregiver heard a "thud in his room." I didn't sat that time. I got him e had any pain, he sad signed the incident ter the incident. The identity is at the incident. The identity is at the incident. The identity is at the incident. The identity is at the incident and the caregivers to care for him after dated 6/9/07 at 12:30 dom Resident A was underwear pulled down as there for a long is dry." The caregiver to come to the facility is any are new. I cleasent to bed." The facility is any are new. I cleasent to bed." The facility is any are new. I cleasent to bed." The facility is any are new. I cleasent to bed. The facility is any are new. I cleasent to bed. The facility is any are new. I cleasent to bed. The facility is any are new. I cleasent to bed. The facility is any are new. I cleasent to bed. The facility is any are new. I cleasent to bed. The facility is any are new. I cleasent to bed. The facility is any are new. I cleasent to be any any are new. I cleasent to be any are new. I cleasent to be any any are new. I cleasent to be any are new. I cleas	"while see any into bed aid no." report on incident assessed swere the OAM found "on yn covered time "called" y to assist caregiver ts and aned room ity RN had 6 days after of document and when to care for 50 AM empted to n his hit his head a bandage incident been no of his				
1	An incident repor	t dated 7/13/07 at 5:0	MA OC	1			

STATEMEN AND PLAN (T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIP A. BUILDING B. WING		(X3) DATE SI COMPLE	
		13R781	CTDEET ADD	DESS CITY S	TATE, ZIP CODE	1012	_, & v v 1
	ROVIDER OR SUPPLIER MEMORY CARE OF N	NAMPA LLC	1	AVE SOUTH			
(X4) ID PREFIX TAG	/EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM.	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
R 008	documented Rand her dresser in her loud noise. "Telfa of to open area on not forehead, open to continue to monito document if the fact the incident and the incident and the assessment compincident. An incident report documented Rand in his wheelchair, scrape on the top had signed the incident. document he had and when the care to care for him after the incident report documented Rand get out of his wheelchair. The facil report on 7/18/07, incident report dicassessed by the fewere instructed or incident. An incident report dicassessed by the fewere instructed or incident. An incident report dicassessed by the fewere instructed or incident. An incident report dicassessed by the fewere instructed or incident.	om Resident E was froom after a caregive dressing with ointmetose. Skid mark with sair. Denies dizzinessir." The incident repocility RN had been not been was no documer deted of her condition dated 7/14/07 at 4:00 dom Resident B. "wou he fell 5 times, he had of his right eye". The cident report on 7/18/The incident report of been assessed by the givers were instructed.	er heard a ant applied swelling on will rt did not otified of other the of the other than after the office of the other than a strying to alance and any e incident office on how the caregivers after the office on his slipped on the other than a strying to alance and any e incident of the other than a strying to alance and any e incident office on the other than a strying to alance and any e incident of the other than a strying to alance and any e incident of the other than a strying to a stryin	R 008			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIF A. BUILDING B. WING	•		ATE SURVEY DMPLETED	
		13R781	T			10/2	2/2007	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	TATE, ZIP CODE			
GRACE	MEMORY CARE OF N	IAMPA LLC	422 11TH NAMPA, II	AVE SOUTH D 83686	I			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
R 008	.25 mg of morphine the resident over a decide what to do." incident report on 7 incident. The incide what had happened give instructions to emergency intervet that was to be followed for the incident report of the incident report incident. The incident report incident. The incident report incident. The incident facility RN had been send him to the EF. An incident report incident report incident incident report incident incident report incident. The incident report incident incident report incident incident report incident incident report incident incident report incident incident report incident incident report incident incident report incident incident incident incident incident incident incident incident report incident report did inc	e. Hospice came and and called his guardia? The facility RN had?/18/07, 3 days after ent report did not dood after the incident not the caregivers regarntion procedures and wed. dated 9/12/07 at 9:20 om Resident D had for the his back after hittings taken to ER per some some some some some some some some	n to signed the the the the the the the the the the	R 008				
	stated there were	40 a.m., the adminis	nđ					

Bureau, of Facility Standards

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLI	
		13R781		B. WING		10/2	2/2007
NAME OF P	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE	<u> </u>	· · · · · · · · · · · · · · · · · · ·
	MEMORY CARE OF N	IAMPA LLC	422 11TH NAMPA, I	AVE SOUTH D 83686			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 008	008 Continued From page 28		R 008			Akinomara	
	when a resident had notify the house may they write those (fastated when a resident he caregivers were She also stated if the caregivers when a resident says no, where the caregivers when a resident said the house may daughter and the composed over the caregivers when a resident said the house may daughter and the composed over the caregivers when a resident said the house may daughter and the composed over the caregivers when a resident said the house may daughter and the composed over the caregivers when a resident said the house may daughter and the composed over the caregivers were said to caregivers were said the caregivers wer	of p.m., a caregiver solent falls the procedulary or if they can standive call the family or the ver admitted she had at did call the house ment fell and hit her he had aughter said that it of the person of the p	rs would where ty RN also a condition e family, gnificant it usually stated that are is to d up. If the he ER." d never manager ead. She is the could wait.				
	don't know how to	e caregiver stated, "I tell if it's something s the resident] or the r	serious,				
	procedure in an er choking or not bre	30 p.m., a caregiver s mergency was to call athing, otherwise to c e supervisor [house r	911 if call the				
	direct staff in an el were conducting n	ar policies and proce mergency. Unlicense nedical assessments nt rather than obtainin	ed staff and	a consistence of the constant			

Bureau of Facility Standards STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		A. BUILDING	E CONSTRUCTION	(X3) DATE SUF COMPLETI	ED
13R781 .		ESS CITY ST	ATE, ZIP CODE	I UI LLI	2001
NAME OF PROVIDER OR SUFFEIER	I22 11TH AVIAMPA, ID	VE SOUTH	ATE, EN GODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FU TAG REGULATORY OR LSC IDENTIFYING INFORMATION	LL ON)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
emergency services or obtaining direction the facility RN. III. Development, Implementation and Upon NSA's 1. Resident #2 was originally admitted to facility on 8/19/04 with diagnoses including Alzheimer's Dementia and was re-admitte facility on 10/09/7 following a hospitalization hip fracture. A. Resident #2's UAI/NSA dated 8/30/07 documented she required verbal cues to great and staff were to cut the resident's prior to serving. There was no documente evidence an interim plan of care or UAI/N been developed after the resident was re-admitted on 10/09/07. The daily care logs dated 10/9/07 to 10/18 (various shifts) documented the resident eaten between 0% and 25% of her meals. The facility nurse's notes dated 10/9/07 documented Resident #2 returned to facilithe hospital, "Appears to have lost a lot or weight." The daily log notes dated 10/11/07 documented Resident #2 "refused solid food" and was weak." The daily log dated 10/13/07 documented Resident #2 "ate a little, put head down of the facility nurse's note dated 10/15/07 documented Resident #2 was "not eating since admission. Choked on mashed pot this morning, requiring Heimlich to clear. notified. Will call [Doctor's name] and get	from dating of he g d to the on for a go to food ed SA had 5/07 had interpretation table."	₹ 008			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPLI	
		13R781		B. WING		10/22/20	
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	STREET ADD	RESS, CITY, ST	ATE, ZIP CODE		
GRACE I	MEMORY CARE OF N	IAMPA LLC	422 11TH A	AVE SOUTH) 83686	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	'FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
R 008	Continued From pa	age 30		R 008			
	days) there was no addressed her dim documented comm	From 10/9/07 to 10/ o nursing documental inished appetite nor nunication to her phy- rers regarding her nuds.	tion that sician nor				
	Resident #2 was s stated she had sur had not "bounced	6 PM the hospice nutarted on hospice too gery for the fractured back." She also state ot consuming fluids a tive swallow."	iay. She d hip and ed				
	Resident #2 had a fall on 9/19/07 and caregiver stated sl	13 PM a caregiver standard decline in her health I had not been eating the refused to eat or continuation at meal and mashed and diet change.	after her well. The drink and				
	Resident #2 did no caregiver stated si	80 p.m., a caregiver sot have an appetite. I have an appetite. I he refused fluids and g on oatmeal and ma	The I meals				
	documented she was to learn up. She independently and transfers. There was interim plan of car	JAI/NSA dated 8/30/0 was able to take care s but required staff a e was "usually" able t I was independent wi vas no documented e e or UAI/NSA had be le resident was re-ad	of her essistance o walk ith evidence an				
	documented Resi	s notes dated 10/9/07 dent #2 returned to fa vas "able to stand," to	acility from				

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPI A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S' COMPLE	ETED
		13R781				10/2	2/2007
	ROVIDER OR SUPPLIER MEMORY CARE OF N	NAMPA LLC		AVE SOUTH	ATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	' FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
R 008	steps with light ham On 10/16/07 at 8:3 observed laying in respond nor open of caregiver said she was on hospice. On 10/17/07 at 3:0 Resident #2 fell an from then on." The total assistance wit position changes of On 10/17/07 at 4:2 stated Resident #2 and as she had no surgery. The facility did not plan of care or NS, interventions to ad hydration intake no how to provide car fractured hip. 2. Resident #6 was 7/15/06 with diagn cancer, and macul Resident #6's clos dated 2/17/07 whice required caregiver with toileting every were to provide sta needed with walke needed.	nds on assist. O AM, Resident #2 wher bed asleep. She eyes when greeted. "wasn't doing very who person a caregiver stated she hall cares and required a caregiver stated she hall cares and required a caregiver stated on hospital bounced back" from the develop Resident #2 A to instruct the caregivers her poor nutritor instruct the caregivers to a resident with the sadmitted to the factors including demelar degeneration. The develop Resident #2 A to instruct the caregivers to a resident with the sadmitted to the factors including demelar degeneration. The develop Resident #2 A to instruct the caregivers to a resident with the sadmitted to the factors and the sadmitted to the factors and the sadmitted to the factors and sadmitted to	did not The The Vell" and Stated "declined required red red resident red a UAI/NSA resident resident regivers resident regivers residers	R 008			
		t Transfer Form" date dent #6 was non-wei					

NAME OF PROVIDER OR SUPPLIER GRACE MEMORY CARE OF NAMPA LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES 10/22/2007 STREET ADDRESS, CITY, STATE, ZIP CODE 422 11TH AVE SOUTH NAMPA, ID 83686 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		A. BUILDING	PLE CONSTRUCTION	(X3) DATE SU COMPLE	
GRACE MEMORY CARE OF NAMPA LLC (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG WITH AMPA, ID 83686 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG WITH AMPA, ID 83686 REGULATORY OR LSC IDENTIFYING INFORMATION) R 008 Continued From page 32 with the right lower extremity. A knee immobilizer was ordered PRN for non-weight bearing, unable to ambulate or to wheel self, unable to transfer self and unable to bear weight or pivot when transferred by another person. It also documented she had a large brace in her room and would be assessed by PT and OT for proper use. The facility nurse's notes dated 5/26/07 document Resident #6 was bleeding from the rectal area and was sent to the ER for an evaluation. She was admitted to the hospital for nausea, vomiting and diarrhea and possible GI bleed and UTI. The resident was discharged back to the facility on 5/29/07 with an order for hospice.			13R781		B. WING		10/2	2/2007
CALL DEFICIENCY NAMPA, ID 83666	NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
R 008 Continued From page 32 with the right lower extremity. A knee immobilizer was ordered PRN for non-weight bearing, unable to ambulate or to wheel self, unable to transfer self and unable to bear weight or pivot when transferred by another person. It also documented she had a large brace in her room and would be assessed by PT and OT for proper use. The facility nurse's notes dated 5/26/07 document Resident #6 was bleeding from the rectal area and was sent to the ER for an evaluation. She was admitted to the hospital for nausea, vomiting and diarrhea and possible GI bleed and UTI. The resident was discharged back to the facility on 5/29/07 with an order for hospice.	GRACE	MEMORY CARE OF N	IAMPA LLC					
with the right lower extremity. A knee immobilizer was ordered PRN for non-weight bearing status. HH admitted Resident #6 on 5/23/07 and assessed her as right non-weight bearing, unable to ambulate or to wheel self, unable to transfer self and unable to bear weight or pivot when transferred by another person. It also documented she had a large brace in her room and would be assessed by PT and OT for proper use. The facility nurse's notes dated 5/26/07 document Resident #6 was bleeding from the rectal area and was sent to the ER for an evaluation. She was admitted to the hospital for nausea, vomiting and diarrhea and possible GI bleed and UTI. The resident was discharged back to the facility on 5/29/07 with an order for hospice.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY	FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	COMPLETE
following her second hospitalization. A hospice aide intervention sheet dated 6/7/07 documented Resident #6 was a 2-3 person assist during cares. A hospice aide intervention sheet date 6/8/07 documented Resident #6 was a 2 person transfer at all times. On 10/16/07 at 11:00 AM a HH/hospice staff stated Resident #6 was unable to bear weight or pivot, unable to wheel herself and was totally dependent on staff for all her cares. The NSA had not been updated to include Resident #6's significant change in health status. There was no direction to staff regarding her	R 008	with the right lower was ordered PRN for the HH admitted Residuals assessed her as right to ambulate or to wiself and unable to literansferred by anot documented she had would be assesuse. The facility nurse's Resident #6 was be and was sent to the was admitted to the and diarrhea and president was dischibited for the resident was a following her second A hospice aide interested during cares. A hospice aide interested during cares. A hospice aide interested during cares. On 10/16/07 at 11: stated Resident #6 pivot, unable to whe dependent on staff. The NSA had not to Resident #6's sign.	extremity. A knee infor non-weight bearing the extremity and the extremity and the extremity that the extremity the extremity the extremity the extremity the extremity the extremity the extremity the extremity the extremity that the extremity the extremity the extremity the extremity that the extremity the extremity that the ext	nd ng, unable transfer when er room for proper document tal area on. She to the cility on on 5/31/07, on 5/31/07, on transfer e staff weight or totally ude alth status.	R 008			

Bureau of Facility Standards

		I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		13R781		B. WING		10/2	2/2007
NAME OF F	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GRACE	MEMORY CARE OF N	IAMPA LLC	422 11TH NAMPA, I	AVE SOUTH D 83686			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
R 008	brace. Further, neit were included in th outlined the service agency. 3. Review of Resid 10/16/07 revealed 4/18/07 with diagnod hypothyroidism, hy secondary to recer hypertrophy and iro. A. Fluid Restriction on 10/16/07 contained at 4/3/07 which independent with each There were no instead the resident requiring Review of Hospital 4/18/07 documente "Hyponatremia, it and drinking large amounday." Discharge inscalorie ADA diet was a physician's order Resident #5 was pure Review of Resident #5 was pure Review of Resident #5 was pure Review of Resident #5 was pure Review of Resident #5 was pure Review of Resident #5 was pure Review of Resident #5 was pure Review of Resident #5 was pure Review of Hospital A/28/07 he was ad episode to Hospital A/28/07 document.	age 33 ther HH or hospice se NSA which would be provided by the outent #5's closed record the resident was adroses which included ponatremia, purpurious medications, proston deficiency anemials. Resident #5's closed red an interim plan of a documented the restating and could feed ructions to caregivering a fluid restriction. A's discharge summed Resident #5 had appeared that the paunts of water through structions included a lith a 2 L fluid restriction and the facility of	rd on mitted on dementia, crash atic a. ed record of care sident was I himself. It about the 2200 ion. Immented restriction. Indicated 7. On onsive ere for 10 y on sical dated ory of	R 008			

Bureau of Facility Standards

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE S COMPLE		
		13R781	STREET ADD	RESS, CITY, S	TATE, ZIP CODE	10/2	L; LUU I	
	ROVIDER OR SUPPLIER MEMORY CARE OF N	NAMPA LLC	422 11TH	TH AVE SOUTH ,, ID 83686				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
R 008	presented to the er	mergency room with	a low	R 008				
	resident was at Ho documented the re	ot as "severe" as when spital A. Additionally, esident had "evidence with Lasix and fluid	it					
·	plan of care dated resident was indep reminded or cues to due to a poor appe	ed record contained 5/7/07, which docum bendent with eating be to maintain adequate tite. There were no egivers about the restriction.	nented the ut needed intake					
	Plan of Care" date agency was to ass	"Home Health Certified 5/8/07 documented sess nutrition and hydrance with fluid restrict	d the HH Iration					
	documented Reside to monitor with fluit will try hard diabet cooperate with me	egress note dated 5/8 dent #5 continued "to ids, esp. water intake ic candy, gum, ice ch when I told him he o s is problematic to th	be difficult e, and they hips. He did could not		-			
	transmission/phor documented, "Res with 1500 ml (1.5 to have this order ambulatory with do be monitored in the responded "pt. ha	ord contained a "Fax ne order" dated 5/9/0 sident returned to this liter) fluid restriction. removed because re ementia. His fluid inta nis setting." The phys s polydipsia with ass id restriction is medic	7 which s facility We need esident is ake cannot ician ociated					
		sed record contained ch documented he w						

		(X1) PROVIDER/SUPPLI IDENTIFICATION NI 13R781		A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/22/2007	
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, ST	TATE, ZIP CODE	· ·	
	MEMORY CARE OF I	NAMPA LLC		AVE SOUTH			
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Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION N			(X2) MULTIF A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/22/2007		
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Bureau of Facility Standards STATE FORM

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	4/19/07 documentorso/extremities,	Resumption of Care" Ited Resident #5's "ra greater bilateral low outtocks." It also docu	ash covers er					

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPL IDENTIFICATION N 13R781			(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION	(X3) DATE S COMPL	
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RO	resident had "smale extremities with not BLE "3 + edema." HH A's "Generic Notational rash on the legs, of hands. It also does blisters forming of the legs of hands. It also does blisters forming of the legs of hands. It also does blisters forming of the legs of hands. It also does blisters forming of the legs of hands. It also does blisters forming of the legs of hands. It also does blisters forming of the legs of hands. It also does blisters forming the large blisters. "Hospital Doctor's dated 4/23/07 at a physician ordered open areas on the dry with a sterile of with gauze. The provide hands of hands of the legs of hands." Home Health A's dated 4/24/07 does large blisters form dressing change, Review of Reside A was discontinued the hospital on 4/days then was resident to the legs of the legs	II blisters to bilateral o open areas noted a	dated as per had the rebody and "some dated sh on the BLE" s Note" ed the anse the cleaner, pat an areas d the gauze urated or visician on of a LE. dervention" #5 had "very uring ted." ted that HH as admitted there for 10 ity on	R 008			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NU			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
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NAME OF F	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, S	STATE, ZIP CODE		
GRACE	GRACE MEMORY CARE OF NAMPA LLC 422 11TH NAMPA,			AVE SOUTH 83686	1		
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R 008	1 4			R 008			
	revealed an Interim Plan of Care dated 5/7/07 which did not document the resident required any bathing assistance, skin care or wound care. Review of HH B's "Home Health Certification and Plan of Care" dated 5/8/07 documented the caregivers were to "assess exudate, odor, pain, tissue color, redness of wound. Instruct in precipitating factors in precipitating factors to skin breakdown. Instruct in pressure relief/shearing reduction measures." HH B's nurse's progress note dated 5/8/07 documented Resident #5 continued to have a diffuse rash on "his hands, fingers, legs and generally on most of his body. The staff at [facility] applies the [medication cream] BID but the family is concerned that it will again blister as it did a few weeks ago." Resident #5's record contained an UAI/NSA dated 5/9/07 which documented the resident needed SBA with bathing 2 times a week. Caregivers were to stay with him until he had completed the bathing process (wash, dry and dress). There were no documented instructions or preventative measures related to wound care during or after bathing.						
i	HH B's wound nurse progress note dated 5/9/07 documented Resident #5 had a rash to arms, legs and trunk. There are areas of dry eschar to the mid calf and posterior achilles." The wound nurse also documented the "eschar areas" needed to remain clean and dry and if the wounds began to drain, wound gel and dressings would need to be applied.				,		
		se progress note dat dent #5 was seen by					

Bureau of Facility Standards STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CI IDENTIFICATION NUMBER			(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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R 008	his "wounds on hee wound clinic nurse care instructions to changes. HH B's wound nurse documented a fam nurse and stated "searlier today after pfor SNV today." An provide "wound care On 10/16/07 at 3:0 Resident #5 needed bathing. On 10/17/07 at 9:3 stated the resident the time he was at resident needed suresident would becup walking. She stated the time he was at resident did not have the bathroom in the forget to go into the were several times not been emptied at On 10/17/07 at 10: member stated the with mobility and we physician's visit it to assist the resident.	o a family member reals had opened." The gave the family writte provide daily dressing the progress note date ily member had contained the changed leg drespot, had an accident. Nother family member	e HH en wound ng ed 5/13/07 acted the ssings No need to N stated essing and aber ssues at ed the the vould be uld en and ted that the uld go to would ed there ag had mily sistance ent to a pers to stated the	R 008	JENGLINOTY .		
	had a Foley cathet	er after it was placed catheter bag. On one	l as family				

Bureau of Facility Standards

AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE S COMPL	
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R 008	family had to call the request a visit to as and catheter. She adrink a large amout water in the facility resident had open feet were very swo provided the wound. On 10/170/7 at 3:00 resident had blister was admitted into the anxies started to have involved and bandance he was heavy care then became worse time, he did not like involved and providenceds. On 10/19/07 at 11:1 gave a statement in wound care. She stunderstanding, [farth dressing the wound. The facility did not Resident #5's interinstruct the caregiv. The facility admitted whom the facility did capacity, and servite for Residents #5 & emergency service and 5 random residential to affect 1 facility. Finally, the	illed the catheter out is home health agents sess the resident's balso stated the resident of water and had at The family member wounds on both ankillen. She stated the fid care to the resident of p.m., a caregiver stall over his legs when a caregiver stall over his legs when a caregiver stall over his legs when a caregiver stall over his legs when a caregiver stall over his legs when a caregiver stall over his legs. She all initially, then improve a gain. He wandere to sit. The family was ded him with many of the caregiver in the stated "it was my nily members] would	cy to bleeding ent would access to stated the es and his amily had tated the nen he rs on his was so stated ed and d all of the as very his care and nurse ent #5's be or update SA to is. ents for bility, priate care d to obtain t2, #5, #6 d the s in the develop	R 008			

Bureau of Facility Standards

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	Residents #2, #5 and #6. These failures resulted in Inadequate care.						
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Bureau of Facility Standards



C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-5747 FAX: (208) 364-1811

November 15, 2007

Rita Berg, Administrator Grace Memory Care of Nampa LLC 4356 North Nines Ridge Lane Boise, ID 83702

Dear Ms. Berg:

On October 22, 2007, a complaint investigation survey was conducted at Grace Memory Care of Nampa LLC. The survey was conducted by Donna Henscheid, LSW, Polly Watt-Geier, MSW and Karen McDannel, Registered Nurse. This report outlines the findings of our investigation.

Complaint # ID00002695

Allegation: The facility was not conducting criminal background checks.

Findings:

On October 16, 2007 at 9:00 a.m., a review of six employee records was conducted and four of six employees did not have their background checks completed at time of hire.

On October 16, 2007 one employee record documented the employee had no background check completed. Two other employees were hired in January 2006 and their background checks were not completed until March 15, 2007 which was approximately fourteen months after their date of hire. The fourth employee was hired October 23, 2007 and the background check was not completed until August 16, 2007 which was ten months after the date of hire.

Conclusion:

Substantiated but not cited. The facility was not cited because the deficient practice was corrected. Although late, three of the four employees did have their background checks completed and were cleared to work. The fourth employee no longer works for the facility.

Allegation #2:

Staff worked alone in the facility prior to having Cardiopulmonary Resuscitation (CPR)

training.

Findings:

Based on record review and interview it was determined the facility did schedule an

employee to work alone without CPR training.

Rita Berg, Administrator November 15, 2007 Page 2 of 3

On October 16, 2007 at 9:00 a.m., six employee records were reviewed. One of the six employees had no documentation to confirm CPR training had been completed.

On October 16, 2007 at 10:35 a.m., the house manager confirmed the employee had not completed CPR training and had worked alone.

Conclusion:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.600.06.b for not ensuring staff who worked alone were properly trained. The facility was required to submit evidence of resolution within 30 days.

Allegation #3:

Administration did not record or investigate staff concerns regarding the residents' cares.

Findings:

Based on interview and record review, it could not be determined the facility had not responded to staff complaints regarding the residents' cares.

During the survey process October 16, 2007 through 10/18/07, 6 of 6 employees interviewed did not express concern regarding the handling of complaints regarding residents' cares.

On October 16, 2007 at 1:34 p.m., the complaint log was reviewed and contained no documentation of any complaints from staff, residents or families.

On October 16, 2007 at 1:37 p.m., the administrator and house manager stated they were not aware of any complaints from staff or families regarding residents' cares.

Conclusion:

Unsubstantiated. Although the allegation may have occurred, it could not be determined during the complaint investigation.

Allegation #4:

A resident's narcotic log was altered. Entries were scibbled out or not recorded accurately. A notation next to a signature "not my signature" was scribbled out.

Findings:

Based on record review it was determined that staff were not keeping precise narcotic records.

On October 16, 2007 at 1:30 the resident's narcotic logs for hyroco/APAP 5/500 were reviewed. One log was for hydroco/APAP 5/500 (1/2 tablet) PRN for pain and the other was for hydroco/APAP 5/500 (1 tablet) PRN for pain. Both logs were dated November 28, 2006 to December 24, 2006.

The narcotic log for the full tablet dated December 24, 2006 at 12:00 p.m., documented there were 19 tablets remaining, a space was left blank and the next entry on December 24, 2006 at 11:00 p.m. documented there were 21 tablets remaining. This was two tablets more than noted earlier that day.

The narcotic log for the 1/2 tablets dated December 18, 2006 at 8:00 p.m. documented there was 21 tablets remaining and a space was left blank. The next entry dated December 24, 2006 at 11:00 p.m., documented no medication was given but there was

Rita Berg, Administrator November 15, 2007 Page 3 of 3

19 (1/2) tablets remaining which was two tablets less than noted six days earlier. Also noted on the 1/2 tablet log was a signature of a staff person and written to the side of the signature was a notation "not my signature" which was scribbled out.

Conclusion:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.310.03 for not ensuring narcotic records were kept accurately. The facility was required to submit evidence of resolution within 30 days.

Allegation #5:

The facility employed a caregiver who was only 16 and was not a certified nursing assistant (CNA).

Findings:

Based on interview and record review, it was determined the facility had employed a caregiver who was 16 years old and not a certified nursing assistant (CNA).

On October 16, 2007 at 9:00 a.m., four employee records were reviewed. One record documented an employee was hired on October 23, 2006 who was under 18 years of age. No documentation was found regarding this employee's nursing assistant certification. Further, review of the work schedule revealed this employee was listed to work several shifts throughout a six month timeframe.

On October 16, 2007 at 9:15 a.m., the house manager confirmed the employee was only 16 years old when hired. The house manager confirmed the registry was not checked prior to the employee being hired.

On October 16, 2007 at 9:55 a.m., the Regional CNA Registry was contacted and they confirmed this employee was not listed on the registry as certified.

Conclusion:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.215.12 for hiring an employee under 18 years of age who was not a CNA. The facility was required to submit evidence of resolution within 30 days.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Fally Wart Leur, MSW.
POLLY WATT-GEIER, MSW.

Team Leader

Health Facility Surveyor

Residential Community Care Program

PWG/sc

c:

Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program Polly Watt-Geier, MSW, Health Facility Surveyor



BUREAU OF FACILITY STANDARDS P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Grace Memory Care of Nanpa	422 11th Ave South	(208) 442-8200
Administrator (City	ZIP Code
Rita Bera	Nampa	8348G
Survey Team Leader	Survey Type / 1	Survey Date
Polly Watt-Geier	Complaint Inurshachun/ Standard Survey	10/20/07
NON-CORE ISSUES		

Kita R. Survey Team Leader	Ur a	Nampa	83686
Survey Team Leader		Sun(ey Type	Survey Date
	H-Geier	Complaint Investigation/ Standard	10/22/07
NON-CORE IS	SUES		
ITEM RULE # 16.03.22		DESCRIPTION	DATE BFS RESOLVED USE
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	the Staff. to include en	revisency services lintervention and acce	ptable
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	course worked at the fac	ilda	
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· ·	Jarca (i.e. launday room).	3	20,000,000
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le 310.04.	a The facility did not afternot	- behavioral interventions prior to using	behavior
	molifying medications.	· · · · · · · · · · · · · · · · · · ·	
7 350.02		e did not complete an investigation for	or each
	accident or incident		
8 350.07	The facility did not markly	the Licensing and Survey Agency with	of Old laws
	of reportable incidents.	THE DIGHTSING WAIT WATER THE PRESENCE WATER	(iii) ~ - Pioni >
	O. ICPOLENCE INCIDENTS.		
Response Required Da	te Signature of Facility_Representative		Date Signed
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BUREAU OF FACILITY STANDARDS P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING Non-Core Issues Punch List

Facility Name		Display (ad Addison	1		-in-out-of-out-out-of-
	۸ ،	Physical Address	Phone Number		
Grace Mamora	Pere of Nampa	City Aug South	(208) 442-	8200	
		City	ZIP Code	Ur not	
Rita Berg Survey Team Leader		Nampa	83686		
•		Survey Type	Survey Date		
Polly Watt-	Geiler	Complaint Investigation/ Standard	10/00/07		
NON-CORE ISSU					
ITEM RULE#		DESCRIPTION	4590809060606		BFS
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	Aide certification.				
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Response Required Date	Signature of Facility Representative				
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11/22/07	Hota Dea			10/22/0	7



BUREAU OF FACILITY STANDARDS P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888 ASSISTED LIVING Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Grace Memory Care of Nampa	422 11th Ave South	(208) 442 - 8260
Administrator	City	ZIP Code
Rita Bera	Nampa	83686
Survey Team Leader \(Survey Type	Survey Date
Polly Watt-Greier	Complaint Investigation / Standard	10/02/07

	Rita B Team Leader	era	Nampa Survey Type	83686		
			Survey Type	Survey Date		
	Polly Wa	H-Greier	Complaint Investigation / Standard	10/02/6-	1	
NON-	-CORÉ ISSU	ES				
ITEM #	RULE# 16.03.22		DESCRIPTION		DATE RESOLVED	BFS USE
		(11/8/07) A parties of	the core deficiency citations was	s reduced		0.00
		to a punch list item	the core deficiency citations was			. no. 40 513
		,				
13	305.62	The facility RN did not e	insure Residents #2 and #4 had	current		
		medication orders.				25 99 50
						10 F2 15 12 F2 15
-						1000
-	se Required Date	Signature of Facility Representative			Date Signed	
<u> 6</u>	70/07					

BFS-686 March 2006